UTAH ACCIDENT & HEALTH SURVEY INSTRUCTIONS

All Fraternal, Health, Life and Property & Casualty insurers in Utah who report accident and health business on the Utah State page of the NAIC Annual Statement are required to complete and file this annual survey. All other insurers are exempt. The completed survey form should be mailed to the Utah Insurance Department **by March 1, 2006**. Submissions may also be made via email to jhawley@utah.gov. *Failure to file by the deadline may subject your company to the enforcement penalties under Utah Code Annotated § 31A-2-308.* Any questions on completing this survey form should be directed to Jeff Hawley, Research Analyst at (801) 538-9684.

This survey is designed to collect accident and health data in greater detail than is reported on the Utah State page of the NAIC Annual Statement. The survey follows definitions and categories used in the NAIC Annual Statement as much as possible. All data values reported on the survey form should represent the year-end totals of the report year (December 31, 2005) and be consistent with the Utah specific data reported on the NAIC Annual Statement for 2005.

The survey form is divided into six parts. In parts I, II, and III, all data reported should represent direct insured business in the State of Utah only. In part IV, all data reported should represent administration of non-underwritten Utah medical plans only. All other types of insured business should be excluded from part IV. Part V is specific to the current marketing efforts of accident & health insurance in Utah and is independent of the NAIC annual statement. Part VI is only applicable to insurers offering Medicare Supplement policies.

Please remember that direct insured business means business where the insurance company bears the underwriting risk prior to ceding or assumption and should include all Utah residents (even if your company wrote the policy in another state and the insured member later moved into Utah). If your company did not report any direct accident and health insurance business in Utah (i.e., zero reported for direct accident and health business in Utah on the Utah State page), then your company is exempt from filing the survey form.

COLUMN DEFINITIONS

PARTS I, II, or III:

NUMBER OF INSURED MEMBERS:	For individual policies, the number of insured members must include dependents. For group policies, the number of insured members must equal the number of certificate holders plus dependents.
NUMBER OF INSURED POLICIES:	For individual policies, enter the number of insured policyholders. For group policies, enter the number of certificate holders. This column is required for parts I and II only.
DIRECT PREMIUMS WRITTEN:	Enter the total premiums collected for policies written during the report year for each A&H insurance category.
DIRECT PREMIUMS EARNED:	Enter the portion of premium paid by the insured that was allocated to the insurer's loss experience, expenses, and profit during the report year for each A&H insurance category.
DIRECT LOSSES PAID:	Enter the actual amount of losses paid by the insurer during the report year for each A&H insurance category.
DIRECT LOSSES INCURRED:	Enter the total amount of losses incurred by the insurer during the report year for each A&H insurance category.

PART III:

CUMULATIVE MEMBER MONTHS:	Enter the cumulative year-end member months for each comprehensive hospital & medical plan category. If you report comprehensive premium, you must report member months, even if the insured members is zero at the end of the calendar year. To calculate member months, first count the number of insured members during each month of the year. This produces 12 member counts (one for each month). Then sum total all 12 member counts. This total is the cumulative member months for the year. For example, if your company had 10 insured members during each of the 12 months of the year, the cumulative member months would be calculated as follows: 10 members x 12 months = 120 member months.

PART IV:

NUMBER OF MEMBERS:	Enter the total number of members in self-funded medical plans administered by the insurer.
ADMIN. INCOME:	Enter the total dollar amount of administrative income received by the insurer for administrating self-funded medical plans.
CLAIM ACTIVITY:	Enter the total dollar amount of claims processed by the insurer while administrating self-funded medical plans.

SELECTED ROW DEFINITIONS

PART I:

COMPREHENSIVE HOSPITAL & MEDICAL:	Business that includes major medical, comprehensive medical and other hospital-surgical-medical benefit plans designed to be the insured member's primary health benefit plan. If Comprehensive Hospital & Medical is reported, part III must also be completed.

MEDICAL ONLY:	Medical only contracts such as medical only, expense reimbursement and indemnity plans.
MEDICARE SUPPLEMENT:	Business reported in the Medicare Supplement Insurance Experience Exhibit of the annual statement. If Medicare Supplement is reported, part II must also be completed.
DENTAL ONLY:	Policies providing for dental only coverage issued as a stand alone dental or as a rider to a medical policy that is not related to the medical policy through deductibles or out-of-pocket limits.
VISION ONLY:	Policies providing for vision only coverage issued as stand alone vision or as a rider to a medical policy that is not related to the medical policy through deductibles or out-of-pocket limits.
FEDERAL EMPLOYEES (FEHBP):	Business allocable to the Federal Employees Health Benefit Plan premium.
Title XVIII MEDICARE:	Business where a premium is collected and the insurer covers the full medical costs of Medicare subscribers.
Title XIX MEDICAID:	Business where a premium is collected and the insurer covers the full medical costs of Medicaid subscribers.
STOP LOSS:	Stop loss insurance coverage for a self-insured group plan, a provider/provider group or non-proportional reinsurance of a medical insurance product.
DISABILITY INCOME:	Policies providing coverage for loss of income resulting from a disability.
LONG TERM CARE:	Business allocable to Long Term Care coverage. If Long Term Care is reported, part II must also be completed.
CREDIT A&H:	Policies providing for credit disability insurance. Excludes credit unemployment, credit life, and credit property insurance.
ALL OTHER A&H:	Other coverage not specifically addressed in any other columns.
TOTAL ACCIDENT AND HEALTH:	Sum total of all of the A&H categories listed previously. This line (line 14, part I) must balance with the total accident and health premium and losses reported on the Utah State page of the Annual Statement.

PART II:

INDIVIDUAL:	Long Term Care policies issued to an individual person.
GROUP (2 or more):	Long Term Care policies issued to a group organization.
MEDICARE SELECT:	Any Medicare Supplement policies that qualify under the Federal requirements for Medicare Select.
ALL OTHER MEDICARE SUPPLEMENT:	All other Medicare Supplement policies. Exclude any Medicare Select policies.

PART III:

TRADITIONAL HEALTH PLANS:	Any standard comprehensive or major medical policy regardless of deductible (e.g., if it is not eligible as a High Deductible Health Plan for use with a Health Savings Account, it is categorized as “Traditional”). Exclude any HSA eligible health plans.
HIGH DEDUCTIBLE PLANS:	Any comprehensive or major medical policy that qualifies as a High Deductible Health Plan under the Federal eligibility requirements for use with a Health Savings Account (HSA). Exclude any plan that is not an HSA eligible health plan (e.g., Traditional health plans).

PART III (Continued):

Group Size Categories

INDIVIDUAL:	Insured policies issued to an individual person. Exclude individual conversion policies.
SMALL GROUP (2 to 50):	Uses HIPPA definition of small group size. Insured policies issued to a group organization.
LARGE GROUP (51 or more):	Uses HIPPA definition of large group size. Insured policies issued to a group organization.
CONVERSION:	Individual insured policies that have been converted from a group insured policy.
GRAND TOTAL COMPREHENSIVE:	Total insured comprehensive hospital & medical business in Utah. This line (line 5.0, part III) must balance with the comprehensive hospital & medical data reported on line 1, part I.

Product Categories

FEE FOR SERVICE (FFS):	Under a Traditional Indemnity or Fee For Service plan (FFS), the insured member can use any provider they choose (as long as the services are a covered benefit under the insurance plan). There are no preferred provider networks and all services are reimbursed at the same cost sharing level (usually a fixed percentage of billed charges) regardless of which physician they choose. The insured member typically faces a deductible and coinsurance above the deductible. Only licensed Accident & Health insurers can offer FFS plans in Utah. However, if the FFS plan includes a PPO rider that allows individuals to pay a lower co-payment or coinsurance rate when they visit doctors or obtain medical services from a network of preferred providers, then the plan should be classified as a PPO for the purposes of the survey (see "Preferred Provider Organization Plan (PPO):").
PREFERRED PROVIDER ORGANIZATION PLAN (PPO):	Under a Preferred Provider Organization plan (PPO), the insured member has lower deductibles and coinsurance if they use physicians or hospitals in the preferred provider network. PPOs cannot limit members to the preferred provider network only, as this would be an EPO arrangement and PPOs are prohibited from doing this under Utah code. Rather, members have a financial incentive to stay within the preferred provider network, as costs are lower if they use preferred providers. Members are free to use any provider outside the network, but services are reimbursed at a lower rate and typically members must pay higher costs to do so. Only licensed Accident & Health insurers can offer PPO plans in Utah. However, if the PPO plan requires permission from a primary physician or gatekeeper, or requires some other form of pre-authorization prior to receiving services from a non-preferred provider that is outside of the network, then the plan should be classified as a PPO with POS features for the purposes of the survey (see "Preferred Provider Organization Plan with Point of Service Features (PPO w / POS):").
PREFERRED PROVIDER ORGANIZATION PLAN WITH POINT OF SERVICE FEATURES (PPO w / POS features):	Special category for certain types of PPOs. Use this category if the PPO plan requires permission from a primary physician or gatekeeper, or requires some other form of pre-authorization prior to receiving services from a non-preferred provider that is outside of the network). See also "Preferred Provider Organization Plan (PPO):"
HEALTH MAINTENANCE ORGANIZATION PLAN (HMO):	Under a Health Maintenance Organization plan (HMO), the member must use the HMO network providers exclusively, except in the case of an emergency. No services provided outside of the HMO network are covered. Only licensed HMOs can offer HMO plans in Utah. However, if the HMO plan has a point-of-service, indemnity carve out, out-of-network rider, or other option where members may use providers who are outside of the HMO network for routine medical services (not emergencies), but at a lower reimbursement rate (e.g., costs the member more to use non-network providers), then the plan should be classified as HMO with POS features for the purposes of the survey.
HEALTH MAINTENANCE ORGANIZATION PLAN WITH POINT OF SERVICE FEATURES (HMO w / POS features):	Special category for certain types of HMOs. Use this category if the HMO plan has a point-of-service, indemnity carve out, out-of-network rider, or other option where members may use providers who are outside of the HMO network for routine medical services (not emergencies), but at a lower reimbursement rate (e.g., costs the member more to use non-network providers). See also "Health Maintenance Organization Plan (HMO):"
OTHER PLANS:	All other category for plans that do not fit into any of the previous categories.

PART IV:

SELF-FUNDED HEALTH PLANS:	This category refers to any administrative business (third party administration, administrative services only, or administrative services contract) with a self-funded or ERISA eligible employer-sponsored hospital & medical plan in the State of Utah. Please report the number of members, administrative income, and clam activity (see row definitions for part IV).

PART V:

COMPREHENSIVE HOSPITAL & MEDICAL (TRADITIONAL):	Selling a policy that includes major medical, comprehensive medical and other hospital-surgical medical benefit plans designed to be the insured member's primary health benefit plan, and fits the definition of "Traditional Health Plans" as described in part III (see part III).
COMPREHENSIVE HOSPITAL & MEDICAL (HSA ELIGIBLE):	Selling a policy that includes major medical, comprehensive medical and other hospital-surgical medical benefit plans designed to be the insured member's primary health benefit plan, and fits the definition of "High Deductible Plans" as described in part III (see part III).
MEDICAL ONLY:	Selling medical only contracts such as medical only, expense reimbursement and indemnity plans.

MEDICARE SUPPLEMENT:	Selling Medicare Supplement policies that would be reported in the Medicare Supplement Insurance Experience Exhibit of the annual statement. If selling this type of business, see also part VI.
DENTAL ONLY:	Selling policies providing for dental only coverage issued as a stand alone dental or as a rider to a medical policy that is not related to the medical policy through deductibles or out-of-pocket limits.
VISION ONLY:	Selling policies providing for vision only coverage issued as stand alone vision or as a rider to a medical policy that is not related to the medical policy through deductibles or out-of-pocket limits.
STOP LOSS:	Selling stop loss insurance coverage for a self-insured group plan, a provider/provider group or non-proportional reinsurance of a medical insurance product.
DISABILITY INCOME:	Selling policies providing coverage for loss of income resulting from a disability.
LONG TERM CARE:	Selling policies that provide Long Term Care coverage.
CREDIT A&H:	Selling policies providing for credit disability insurance. Excludes credit unemployment, credit life, and credit property insurance.
ALL OTHER A&H:	Selling accident & health coverage not specifically addressed in any other columns.
COMPANY NOT SELLING A&H:	If your company is ***not*** actively selling any form of accident & health insurance (e.g., all previous categories are “NO”), write “YES” in this category. Otherwise write “NO”.

PART VI:

This section is provides companies with an opportunity to be listed as a Medicare Supplement (Medigap) Provider in Utah (see the part VI on the survey form for details).